APPLICATION FOR A LIMITED LICENSE TO PARTICIPATE IN A POSTGRADUATE TRAINING PROGRAM

State Form 50318 (7-01)
Approved by State Board of Accounts, 2001

HEALTH PROFESSIONS BUREAU
INDIANA BOARD OF PODIATRIC MEDICINE
402 West Washington Street, Room 041
Indianapolis, IN 46204
Telephone: (317) 233-2960

*** Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

FOR OFFICE USE ONLY	
DATE RECEIVED:	
FEE AMOUNT RECEIVED:	
RECEIPT NUMBER:	
FEE INFORMATION:	
LIMITED LICENSE NUMBER:	
DATE ISSUED:	

APPLICANT

Attach one (1) passport-quality photograph of yourself here.

ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.

APPLICANT INFORMATION		
Name (*last, first, middle, maiden or previous*)		
Current address (*number, street or Rural Route*)		
City	**State**	**ZIP code**
Permanent address (*IF DIFFERENT FROM ADDRESS ABOVE*)		
City	**State**	**ZIP code**

Social Security number *	**Date of birth** (*month, day, year*)	**Place of birth** (*city, state*)
E-mail address		

PRE-PROFESSIONAL EDUCATION		
NAME OF SCHOOL	**LOCATION**	**DATES ATTENDED**

DOCTOR OF PODIATRIC MEDICINE DEGREE GRANTED BY:		
NAME OF SCHOOL	**LOCATION**	**DATES ATTENDED**

(*Continued on the reverse side.*)

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plantiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No

3. Are you now being, or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No

4. Have you ever been charged with drug addiction? ☐ Yes ☐ No

5. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ Yes ☐ No

6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No

7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No

8. Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Health Professions Bureau or any of their authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Health Professions Bureau, and the Board of Podiatric Medicine from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date signed (*month, day, year*)

POSTGRADUATE TRAINING VERIFICATION FOR A LIMITED LICENSE TO PARTICIPATE IN A POSTGRADUATE TRAINING PROGRAM

State Form 50318 (7-01)

This form is to be completed by the Hospital / Institution Chairperson / Department Head, notarized and submitted directly to the Health Professions Bureau at the address below:

HEALTH PROFESSIONS BUREAU
INDIANA BOARD OF PODIATRIC MEDICINE
402 West Washington Street, Room 041
Indianapolis, IN 46204
Telephone: (317) 233-2960

This is to certify that _____ has been granted an appointment to serve at

_____ in the Department of _____

located at (*address*) _____

This appointment is for the month and year beginning _____ and ending _____.

Printed name of Hospital Chairman / Department Head	Title
Signature of Hospital Chairman / Department Head	Date (*month, day, year*)
Address (*number and street, city, state, ZIP code*)	
Telephone number	

SEAL OF NOTARY PUBLIC